



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Edward Icaza MD

Respondent Name

Employers Insurance Co of Wausau

MFDR Tracking Number

M4-17-3746-01

Carrier's Austin Representative

Box Number 1

MFDR Date Received

August 21, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134. The carrier has not responded or has denied this claim in its entirety following our filing of Request for Reconsideration. Therefore, we are filing for Medical Dispute Resolution at this time per Rule 133.307."

Amount in Dispute: \$902.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Code 99204 was denied as not supported and included in the procedure diagnostic testing. No significantly identifiable Evaluation and Management Service has been documented, and modifier 25 was not billed with code 99204... CPT Code 99204, was billed in combination with CPT Codes 95910 and 95886 which have "XXX" and "ZZZ" global days. Medicare indicates that E&M should not be billed with "XXX" procedures since the procedure components include the pre-procedure, intra-procedure and post procedure work usually performed each time the procedure is completed. Codes with "ZZZ" global days indicates the services are included in the global period of another related service... CPT Codes 95910 and 95886 were paid at billed charge on check #0303344803 with issue date of 02/09/2017. Code 95910 paid at \$310.73 and Code 95886 paid at \$294.70... HCPCS Codes A4556, electrodes, per pair and A4215, needles sterile any size, were denied as supplies are not separately payable per Medicare guidelines."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 4, 2017	99204, 95886, 95910, A4556, A4215	\$902.54	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - X263 – The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure
 - PNFC – The reimbursement is based on the CMS Physician fee schedule non-facility site of service rate
 - MSCP – In accordance with the CMS Physician fee schedule rule for status code ‘P’, this service is not separately reimbursed when billed with other payable services
 - X212 – This procedure is included in another procedure performed on this date

Issues

1. Are the insurance carrier’s reasons for denial of payment supported for code 99204?
2. Were codes 95886 and 95910 paid per applicable fee guideline?
3. Is the requestor entitled to additional reimbursement for codes A4556 and A4215?

Findings

1. The requestor is seeking reimbursement for professional medical service billed as code 99204 rendered on January 4, 2017.

The insurance carrier denied disputed services with claim adjustment reason code X263 – “The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure.”

28 Texas Administrative Code §134.203 (b) states in pertinent part,

For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

The submitted code in dispute is 99204 – “Office or other outpatient visit for the evaluation and management of a new patient, which **requires these 3 key components**: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.”

Review of the submitted medical documentation with “Electromyography (EMG) Report,” date January 4, 2017 finds the following:

Required Element	Present within Submitted Documentation Findings	Requirement of Code Met
Comprehensive History	History of present illness: one condition = Brief Review of systems: Musculoskeletal = Extended Past medical, family, social history, areas: Past Medical History = Pertinent to Problem History level score = expanded Problem Focused	No

Comprehensive Examination	Body Areas: Each extremity (1) Back Exam Level Score = Problem Focused	No
Moderate complexity medical decision making	Number of Diagnoses or Treatment options points = 1 Amount and/or Complexity of Data Reviewed = n/a Presenting Problem = n/a Level of Decision Making Score = Straightforward	No
Forty-five minutes face to face with the patient/and or family	No documentation found to indicate face to face time	n/a

Based on the above, the carrier's denial X263 – "The code billed does not meet the level/description of the procedure performed/documented" is upheld.

- Review of the DWC060 received with this request for Medical Fee Dispute indicates "0" amount paid for code 95886 and 95910. The respondent states, "CPT Codes 95910 and 95886 were paid at billed charge on check #0030344803 with issue date of 02/09/2017. Code 95910 paid at \$310.73 and Code 95886 paid at \$294.70." Review of the documents submitted with the request for MFDR found the above referenced explanation of benefits. The maximum allowable reimbursement is calculated per the applicable fee guideline found below.

28 Texas Administrative Code §134.203 (c) states in pertinent part,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (year of service annual conversion factor).

Review of the 2017 Physician fee schedule found at www.cms.gov, indicates the allowable found in the table below.

Date of Service	Submitted Code	Physician Fee Schedule	(DWC Conversion Factor/ Medicare Conversion Factor) x Allowable = MAR	Amount Billed	Amount paid by carrier
January 4, 2017	95886	\$93.68	$97.5/35.887 \times 93.68 = \150.09	\$294.70	\$294.70
January 4, 2017	95910	\$202.96	$97.5/35.887 \times \$202.96 = \325.18	\$310.73	\$310.73

28 Texas Administrative Code §134.203 (h) states in pertinent part,

When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the:

- (1) MAR amount;

(2) health care provider's usual and customary charge

Based on the above the carrier paid per the provider's usual and customary charge for codes 95886 and 95910. No additional reimbursement is due.

3. The respondent states, "HCPCS Codes A4556, electrodes, per pair and A4215, needles sterile any size, were denied as supplies are not separately payable per Medicare guidelines."

Review of the applicable Medicare payment policy www.cms.gov, for each of these disputed codes finds:

- Code A4556 – Status Code "P" Bundled/Excluded Codes
- Code A4215 – Status Code "X" Statutory Exclusion

Based on the above, the Carrier's denial and response is supported. No separate reimbursement recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

September 13, 2017
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.